Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of

Actions to Accelerate Adoption and Accessibility of Broadband-Enabled Health Care Solutions and Advanced Technologies	))))	GN Docket No. 16-46

COMMENTS OF THE SCHOOLS, HEALTH & LIBRARIES BROADBAND (SHLB) COALITION

The Schools, Health & Libraries Broadband ("SHLB") Coalition[1] appreciates the opportunity to submit these comments in response to the Public Notice[2] on improving broadband-enabled health care solutions.

The Public Notice itself outlines the many advantages of rural telehealth networks. Telehealth networks can be used to provide immediate emergency evaluation of patients through videoconferencing that was not available 10 years ago, saving hours of driving to an urban hospital. Telemedicine also enables remote patient monitoring at home that can save lives and deliver care more quickly. Telehealth networks also allow doctors to see more patients, creating a win-win for both doctors and patients.

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[1] SHLB Coalition members include representatives of health care providers and telehealth networks, schools, libraries, state broadband offices, private sector companies, state and national research and education networks, and consumer organizations. See www.shlb.org for a current list of SHLB Coalition members.

[2] See "Public Notice: FCC Seeks Comment And Data On Actions To Accelerate Adoption And Accessibility Of Broadband-Enabled Health Care Solutions And Advanced Technologies," released April 24, 2017 (FCC 17-46) available at https://ecfsapi.fcc.gov/file/04242338715026/FCC-17-46A1.pdf.

Furthermore, high-speed broadband is increasingly necessary for the transfer of electronic medical records (EMR). Very few health care facilities have EMRs on site. The model used by most EMR providers is to manage the servers in central facilities/cloud and not leave it to sites to manage themselves. Therefore, when circuits are too slow or go down, even for a few seconds, it interrupts the ability of health care providers to provide patient care. Telehealth and telemedicine are fantastic tools with the promise to deliver better and more cost-effective healthcare, but first health care providers need reliable and consistent access to the EMR.

A. Changes in the Market Warrant a Comprehensive Modernization of the Rural Healthcare Program.

The SHLB Coalition strongly believes that the Rural Health Care (RHC) program needs to be modernized to reflect several significant changes in the law and the marketplace in recent years:

1) The closing of 80 rural hospitals since 2010[3] has exacerbated the severe shortage of traditional medical care in rural communities, making it even more important that the FCC expand the RHC program to fill the urgent need for higher quality health care through telemedicine.

2) Demand for bandwidth by health care providers is booming. The use of cloud-based Electronic Health Records (due to passage of the HITECH Act),[4] multi-gigabit MRIs and CT scans are driving an increased demand for bandwidth need. Insurance claims processing is all online, as are reporting requirements and access to disease registries. Clinical health

[3] See, http://www.beckershospitalreview.com/finance/a-state-by-state-breakdown-of-80-rural-hospital-closures.html.

[4] The **HITECH Act**, enacted as part of the American Recovery and Reinvestment **Act** of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology.

information exchange and care coordination both rely on connectivity. Some telehealth networks report that demand is growing 50% per year.[5]

3) Many remote and rural health clinics do not have the broadband capabilities that they need to keep up with this demand. Tribal health clinics are particularly underserved by broadband networks. In fact, the gap in the bandwidth available to rural health care providers compared to comparable urban providers is increasing. Professor Brian Whitacre at Oklahoma State University used data from the National Broadband Map to determine that 59% of non-metro health clinics have less than a 10 Mbps connection, and showed that the bandwidth gap between urban and non-metro health centers has increased substantially.[6] This is very disturbing. Ten Mbps is at the low end of what a residential consumer needs. A health center should have 50 or 100 Mbps at a minimum.

4) The $400 M cap in the RHC program was reached for the first time in FY 2016, which resulted in many applicants suffering a 7.5% reduction in funding. The growth in applications and the 7.5% reduction in funding has created enormous uncertainty in the applicant community, which has in turn caused many telehealth network expansion efforts to be stopped in their tracks.

5) Congress added Skilled Nursing Facilities to the list of eligible entities without adding any additional funding

6) It is not clear whether the streamlining of consortium applicants promised in 2012 has occurred. The purpose of creating the Healthcare Connect Fund (HCF) in 2012 was to drive greater investment to enhance broadband connectivity for health providers across the country. In

[5] The California Telehealth Network sites report that demand for live video consultations over broadband is growing at over 60% per year.

[6] http://www.dailyyonder.com/rural-healthcare-falls-further-behind-in-broadband-speeds/2016/03/15/12049/.

fact, the HCF rules and application processes have proven difficult and have not accomplished the goal of driving greater rural broadband investment. Indeed, many organizations have chosen to continue using the legacy Telecommunications Program rather than convert to the HCF.

For all these reasons, the SHLB Coalition continues to support the initiation of a rulemaking proceeding as requested in our Petition for Rulemaking[7] filed with six other telehealth networks in December 2015. The experience of our community is that in important respects the rules adopted in 2012 are not working as intended. In addition, the rules for the Telecommunications program component of the RHC program have not seen significant change since they were first adopted 20 years ago.[8] This view that the RHC program is not meeting its goals is widely shared by the health community; all five health organizations that submitted initial comments in response to our Petition in January 2016 supported the initiation of a rulemaking proceeding.[9] The Petition was also supported by several others, including MOREnet, TracFone, and the Utah Education and Telehealth Network. To the extent that some commenters cited the need for more data and factual experience with the operations of the RHC program, we agree. The Commission should use the initiation of an NPRM proceeding in the

[7] Wireline Competition Bureau Invites Comments on Petition for Rulemaking Filed by Schools, Health & Libraries Broadband Coalition, et al., Seeking Further Modernization of the Rural Health Care Program, CC Docket No. 02-60, DA 15-1424 (rel. Dec. 15, 2015), ("Petition").

[8] See ex parte presentation of Alaska Communications, Inc. (". . . we urged the Commission to modernize the rules governing the Telecommunications Program. The core of those rules was written two decades ago for a world of low-bandwidth, circuit-switched services. Increasingly, the rules do not provide a meaningful framework within which health care providers can confidently seek support for modern, Ethernet-based services.") https://ecfsapi.fcc.gov/file/10511215195863/Ex%20parte%20letter%20re%20Rural%20Health%20Care%20(FINAL%202017-05-10).pdf.

[9] See comments of the American Telemedicine Association (ATA), HIMSS, PCHA, the University of Arkansas for Medical Sciences, and the American Hospital Association (AHA).

RHC program to conduct a fact-based, data-driven inquiry into the broadband needs of the rural health providers to inform potential solutions.

B. Bandwidth Pricing in Rural Markets Remains High in Many Markets.

High prices continue to be a significant problem for rural health providers. The Utah Education and Telehealth Network (UETN) has recently obtained pricing for both urban and rural broadband services and can attest that, in some rural locations, competitive pricing continues to be a challenge.

Because of the urban/rural disparities in pricing, it is less feasible for UETN to "postalize" rates across a bandwidth level. In the past UETN was able to offer an average price across a bandwidth level for its UETN member sites. This reduced urban discounts somewhat but significantly improved pricing for the most remote sites. However, given the disparity in pricing that remains between urban and rural and the reduced discounts, this no longer appears feasible. Averaging prices by bandwidth would increase costs too much for urban HCPs, creating a disincentive for their participation in the UETN consortium. Their participation is important as it helps distribute the fixed costs of network management over a broader set of members' sites.

The FCC should consider two steps to address these excessive prices for bandwidth in rural markets:

First, the FCC should consider making prices for RHC services more transparent. This data is collected on Form 462/466, but it is not published. Making this pricing information publicly available could help health clinics compare and benchmark their rates with other similarly-situated customers.

Second, the FCC should consider increasing the discount for rural health care providers compared to urban providers. Currently the rules call for a flat 65% subsidy for all providers,

which is significantly lower than the subsidy provided to many schools and libraries in the E-rate program. The FCC should consider returning to the 85% subsidy for rural HCPs as in the Pilot Program.

C. Connecting Rural Health Care Providers Requires an Investment of Capital that Can Be Fiscally Responsible.

Building broadband networks requires an investment of capital. Fiber cables can contain dozens of strands of fiber, each capable of carrying huge amounts of data for decades into the future. Deploying fiber is a long-lasting investment that will lower medical care costs and promote economic growth.

Obviously, this requires funding. The $400M per year cap on spending in the RHC program is woefully arbitrary and inadequate. The E-rate program is capped a $4 billion, ten times more than the RHC program, when it can be argued that rural health care is just as important. The $400M cap was set rather arbitrarily 20 years ago and has not kept up with changes in the marketplace, especially the rural hospital closures and the addition of Skilled Nursing Facilities to the list of eligible entities.[10] Furthermore, the number of health care sites has grown significantly since 1997 to accommodate the growth in population, and broadband is a much more critical component of health care than 20 years ago.

Raising the cap on the RHC program could be accomplished without a material change in the contribution factor. Because the $400 M RHC program is less than 5% of the overall USF, which is now about $8.8 billion, increasing the size of the RHC program would be barely

[10] See the comment of the Peninsula Community Health Services of Alaska, already submitted in this proceeding, which says "We believe that the FCC should increase the budget for the rural health care support mechanisms to reflect inflation over the past two decades, as well as increased technology and telecommunications demands due to our HIPAA legal obligations, advances in telemedicine capabilities, changes in patient expectations and standards of care, and new demands from skilled nursing facilities." Peninsula comments, p. 2.

noticeable and would fall within the range of the quarter-to-quarter fluctuations in the contribution factor.[11] Thus significantly increasing RHC funding – for instance, to $800 M per year – could very likely be accommodated without the contribution from consumers rising above the 20% level.

Several senators wrote to FCC Chairman Pai supporting the idea that unused RHC money from prior years could be rolled over for future years, as is current done with the E-rate program.[12] We support the Senators' recommendations to fill the short-term funding shortfall.

D. The FCC Should Conduct a Data Gathering Exercise to Determine the True Cost of Upgrading the Broadband Capabilities of Rural Health Care Providers.

Ultimately, however, the amount of funding made available through the RHC program should not depend on mathematics based on an outdate cap calculation, it should be based on the current and projected broadband needs of rural healthcare providers. It is clear that much more funding will be needed if we as a nation are going to seriously address the rural health care crisis. How much funding is required is not known at the present time, largely because of a lack of data. We encourage the FCC to work with state organizations to collect the data necessary to make proper decisions. The FCC engaged in an intensive data-gathering effort around Business Data Services/special access over the past few years. Gathering data on the number of eligible health providers and their broadband connections would not be nearly as time-consuming as the BDS data gathering proceeding, and could be even more beneficial.

[11] For instance, if the cap for the RHC program were raised to $800 M, the overall size of the USF would increase from its current size of $8.8 B to $9.2 B, an increase of 4.5%. This would raise the contribution factor from roughly 17.4% to 18.2%). The contribution factor has vacillated from 16.7% to 18.2% over the past two years.

[12] https://www.king.senate.gov/newsroom/press-releases/king-leads-letter-calling-on-fcc-to-protect-broadband-funding-for-rural-healthcare-clinics-in-maine.

There is also an interesting legal question concerning the cap. In section 254(h)(1)(A) says that telecommunications carriers "shall" make service available to rural health care providers at rates that are reasonably comparable to rates in urban areas. This language suggests that the carriers, and the FCC, do not have the discretion to reduce the funding available to meet this statutory requirement, even if the demand is greater than the FCC's cap on the program. In other words, it may not be permissible under the statute for the FCC to impose a cap on funding for the Telecommunications program component of the RHC. The SHLB Coalition has just begun to explore this issue, and we will look into the question further. Eliminating the cap for the Telecommunications Program would also remove the uncertainty about future funding and provide more predictability for applicants.

E. The FCC Should Encourage Network Sharing to Reduce Costs for All Users and Eliminate Silos.

As the FCC considers how to improve telehealth networks in the future, it is very important not to create new silos that prevent the efficient sharing of network infrastructure. It would be duplicative and wasteful to build separate fiber networks – one for health, one for schools, another for libraries, and yet another for commercial customers. Fiber networks contain dozens of individual fiber strands that can be shared and built to benefit the entire community. This is especially important in rural markets that have trouble maintaining one network, let alone several. Given the difficult economics of providing broadband to sparsely populated rural America, we encourage the FCC to break down the current funding silos for E-rate, Rural Health Care and the Connect America Fund. By allowing funding from these programs to work together, the cost of providing broadband to rural communities becomes more viable than funding separate networks based on the funding source. We urge the FCC to fund networks using public-private partnerships that serve the needs of rural health providers, schools, libraries

and other community anchor institutions as a whole. Sharing these networks among multiple users stretches limited universal service funding, lowers the costs for all, and helps ensure high-capacity broadband will be deployed to every community in America.

F. Conclusion

In conclusion, the SHLB Coalition makes the following recommendations:

1. Issue a Notice of Proposed Rulemaking (NPRM) to modernize the RHC program, as requested by the SHLB Petition filed in 2015;

2. Use that NPRM to embark on a data gathering proceeding to determine the number of eligible health care entities and estimate the cost of upgrading their level of broadband connectivity;

3. Adopt a rule similar to the roll-over rule in the E-rate program to allow funds that are committed but not disbursed to be used to cover future applications.

4. Make the rates charged to Health Care Providers more transparent and publicly available to facilitate benchmarking.

5. Consider increasing the RHC support for rural HCPs to 855 to improve the flow of dollars to rural HCPs.

6. Improve the processing of consortia applications. The FCC and USAC should find ways to speed the processing of the various forms (460s, 461s, 462s) and should also find ways to streamline the treatment of individual health care sites.

7. Consider eliminating the cap on the Telecommunications Program to be consistent with the mandate in the statutory language.

8. Significantly raise the cap for the Healthcare Connect Fund to promote greater investment in rural markets and otherwise ensure that the entire RHC program provides a predictable amount of universal service support.

9. Promote network sharing by explicitly allowing health networks and networks funded by E-rate, Connect America Fund and other programs to be used by health care providers to lower the costs for all programs.

Sincerely,

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